The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice

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THERE IS GROWING RECOGNITION THAT MUCH OF society's economic burden of illness is attributable to systemic community problems, such as substance abuse, violence, teen-age pregnancy, and environmental pollution (Citrin 1998; Gamm, Rogers, and Work 1998; Kreuter and Lezin 1998). Failure to address these social determinants adds to the existing burdens on the health and medical care delivery system, whose members face difficult decisions about the allocation of resources as a result of continuing pressures to contain costs. One response to this challenge has been a surge in the number of community health partnership (CHP) initiatives, stimulated largely by private foundations. Increasingly, these partnerships involve cross-sector collaboration.

There are many examples of CHPs across the United States: the Community Care Network (CCN) Demonstration Project (sponsored by the W.K. Kellogg Foundation and Health Research and Educational Trust; the American Hospital Association in collaboration with the Catholic Health Association; Duke Endowment and Voluntary Hospitals of America); Community Health Intervention Partnership (sponsored by the Health Research and Educational Trust); Comprehensive Community Health Models Project (sponsored by the W. K. Kellogg Foundation

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and Brandeis University); Healthy Communities (sponsored by the Department of Health and Human Services and the National Civic League); Community Program for Affordable Health Care (sponsored by the Robert Wood Johnson Foundation); the Comprehensive Community Health Models (CCHMs) initiative; Turning Point Partnerships (sponsored by the Robert Wood Johnson Foundation) in numerous locations throughout the country; the Coalition for Healthier Cities and Communities in the U.S.; the Centers for Disease Control and Prevention (CDC) PATCH model; the CITY–NET Healthy Cities initiative; North Carolina's Community-Based Public Health Initiative; Ohio's Center for Healthy Communities; and Arizona's Partnership for Infant Immunization (TAPII). This list represents only some examples of partnerships that were designed to address a variety of community health problems and mobilize communities to sustain initiatives over time (Tarlov, Kehrer, Hall, et al. 1987; W.K. Kellogg Foundation 1994; McLeroy, Kegler, and Steckler 1994; Butterfoss, Goodman, and Wandersman 1996).

Community health partnerships are defined as voluntary collaborations of diverse community organizations, which have joined forces in order to pursue a shared interest in improving community health (Kramer and Specht 1969; Black 1983; Brown 1984; Butterfoss, Goodman, and Wandersman 1996; Wandersman, Valois, Ochs, et al. 1996; Kreuter and Lezin 1998). We define the term "partnership" to include coalitions, alliances, consortia, and related forms of interorganizational relations created to improve health. The broad cross-sectoral composition and voluntary nature of CHPs distinguish them from other health care or public health organizations. CHPs differ from traditional community organizations in their mix of public and private members, and they diverge from grassroots organizations in their inclusion of multiple constituents and stakeholders.

Despite their growing popularity, however, evidence from demonstration projects and case-study evaluations of CHPs indicate that they frequently fail to achieve measurable results (Knoke and Wood 1981; Wandersman, Goodman, and Butterfoss 1993; Cheadle, Berry, Wagner, et al. 1997). Problems associated with the governance and management of CHPs have been cited as possible reasons for the inability of these organizations CHPs to demonstrate significant, measurable outcomes (Kreuter and Lezin 1998; Wickizer, Wagner, and Cheadle 1998; Lynn, Heinrich, and Hill 1999), and the literature on interorganizational partnerships is filled with examples of the difficulties inherent in sustaining

successful relations among diverse partners (Duhl 1995). Community health partnerships face qualitatively different challenges from those confronting individual organizations in either the public or the private sector. CHPs must attend more closely to aligning member interests, achieving domain consensus, managing conflict and turf issues, and providing evidence of achievement and changes in health outcomes (Weiner, Alexander and Zuckerman 1998; Weiner and Alexander 1998).

There is little systematic research on the governance and management of CHPs (Alexander, Comfort, and Weiner 1997). In order to move forward, we need to devise a systematic way of thinking about which dimensions of governance and management contribute to the effectiveness of CHPs. The governors and managers, as well as the funders and evaluators, of CHPs would benefit from a theoretically based conceptual framework that would serve as a guide in constructing, maintaining, and measuring successful interorganizational relations.

In this paper, we apply a multidisciplinary perspective to construct a typology of effective governance and management characteristics of CHPs, based on notions of external and internal alignment. We define governance as being primarily concerned with positioning the partnership relative to the external environment within which it operates.

Governance involves a number of tasks:

- setting priorities for strategic goals
- choosing the membership composition
- obtaining the needed financial resources
- providing measures of accountability

We define management as being primarily concerned with execution or implementation. Management deals with the following issues:

- engaging and maintaining organizational members' interest in a shared vision and mission
- implementing the chosen strategies by providing appropriate structures and coordination mechanisms
- developing ways to promote constructive conflict and manage destructive conflict
- implementing information systems to monitor progress over time
- adjusting to changes that occur in leadership, in the overall membership, and in the community at large
- dealing with related factors

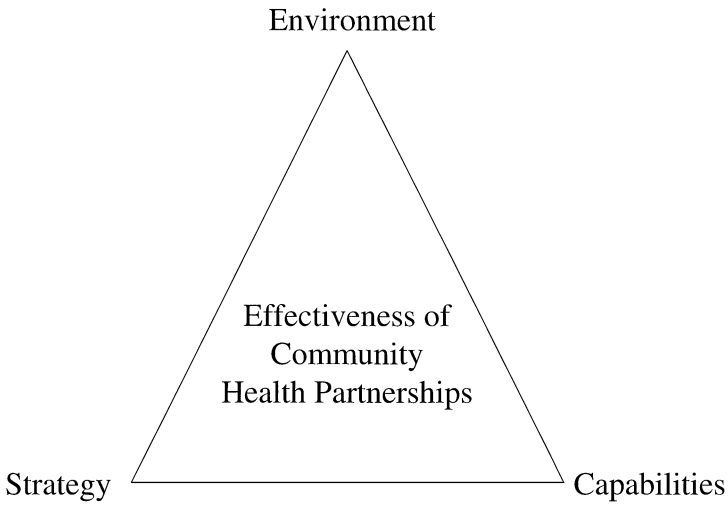


FIG. 1. Triangle of strategic alignment.

Our focus in this paper is broader than that of the emerging literature on board development (Alexander, Zuckerman, and Pointer 1995; Weiner and Alexander 1998; Weiner, Alexander, and Comfort 1998). We base our typology on a synthesis of the literatures from the fields of community organization, social work, business strategy, organizational theory, transaction cost economics, and public health. Some of the central concepts are organized under the headings of governance, management, and environment (fig. 1).

Once we had reviewed the literature and constructed our framework, we were able to identify seven main dimensions of a typology:

1. the nature of the problems addressed
2. partnership composition
3. differentiation
4. coordination and integration
5. accountability
6. centrality
7. alignment

From these dimensions, we derive a set of guiding principles and robust properties that can be the basis for further research and can be used

by policy makers and organizers in planning and decision making. The typology can help to classify important organizational issues, identify barriers to successful development, implementation, and sustainability, and facilitate the attainment of goals.

We first ground CHPs within the context of the community organization literature, although, as we noted earlier, we view CHPs as having a broader scope than grassroots organizations. We then synthesize the most salient findings from our review of the literature. We conclude by suggesting a typology that yields questions and propositions for practitioners and policy makers to consider when they are formulating guidelines and for researchers to use as the basis of further examination.

CHPs in the Context of Community Organization

Although CHPs are relatively new, spawned mostly from large foundation grants or smaller government initiatives, they reflect the ideals produced during a long history of community organization in the United States (Garvin and Cox 1995; Schlesinger 1997). Although CHPs differ from the traditional model of community organization and are less reliant on grassroots activism and support, this model nevertheless provides a context for understanding the environment in which CHPs operate and the challenges they face in developing links among diverse community actors.

Community organization has been described as a process of intervention for the purpose of enabling communities to engage in planned collective action in order to deal with social problems within a democratic system of values (Kramer and Specht 1969). The community organization framework involves two major, interrelated concerns:

1. the processes of planning and organizing, identifying problems, identifying causes, and formulating solutions
2. developing strategies and mobilizing the resources necessary to take action (National Association of Social Workers 1962)

CHPs reflect the community organization framework by serving as a vehicle for collaboration among disparate community actors in order to identify and address health problems in the community and formulate solutions.

Like community organizations, CHPs collaborate voluntarily, a factor that raises unique governance and management issues not encountered by more traditional forms of alliances or partnerships (Alexander, Zuckerman, and Pointer 1995). In contrast to more traditional forms of governance used by business alliances, such as contract law, CHPs tend to rely on social-control mechanisms to ensure that individual organizations adhere to the partnership vision and pursue collective goals. Social-control mechanisms, such as internalization of norms through leadership and socialization, are critical to the governance of community organizations, as they offer a way to ensure that collective, rather than personal, interests will be served by the actions of individuals in the organization. Social control has also been used effectively in community organization as a means of ensuring accountability and resolving disputes between partnership organizations (Knoke and Wood 1981). However, these mechanisms do not carry the power of legal sanctions or fiat as a means of monitoring and controlling the actions and behavior of other organizations. Another similarity between community organization and CHPs is that their mission and goals are formulated to benefit the larger community rather than members of the partnership directly. This distinguishes them from other types of interorganizational partnerships with more traditional goals of profit maximization or individual gain. As such, community organizations and CHPs require different forms of monitoring and control, different mechanisms of accountability and outcomes, and different methods of decision making.

Despite their similarities, CHPs diverge from the community organization model in their greater emphasis on *cross-sectoral*, public–private participation and collaboration. CHPs involve community actors from a greater variety of economic, political, and social spheres, including grassroots organizations. In the same spirit, CHP funding is also diverse; it comes both from the community and from outside public and private funds. Ties to institutions and stakeholders outside the boundaries of the immediate community add to the complexity of CHP governance and management. CHPs differ as well from public health agencies and community health centers, which have stronger government ties. CHPs may have greater flexibility in procuring funds from a variety of sources and more discretion than public, governmental agencies in applying those funds toward specific goals. We will examine the implications of these differences in our review of the literature, which is organized according to the main dimensions of CHP governance and management.

Salient Dimensions of CHP Governance and Management

Strategic Intent and Reasons for Organizing

CHPs are formed to allow a wide spectrum of health problems to be addressed by a large cast of actors, from grassroots community activists to business leaders to politicians. Understanding the context in which a CHP is initiated, the original intent and motives for its initiation, and its major sources of funding is critical for choosing the appropriate, feasible organizational structures and processes for governing and managing the partnership. Any changes in the goals of a partnership or in its sources of funding may affect its governance and management strategies and lead to shifts in organizational constraints and patterns of influence.

For example, research has identified different roles for community organization initiators, depending on their relationship with the community (Rivera and Erlich 1995). Initiators with direct ties to the community are more effective as primary contacts with grassroots community organizations. In contrast, initiators from outside the community are cast more appropriately as liaisons between the community and the larger society, or as consultants who provide valuable knowledge or technical skill. Research on the impact of funding sources has found that they influence both how an an organization defines its "community" and the degree to which the organization's mission and goals reflect "democratic" principles (Rossi 1960).

CHP initiatives are often begun and sustained by professionals whose occupational roles reflect their concerns with community institutions: city managers, school superintendents, public health officers, and citizen and community groups (Rossi 1960). Businesses and other community organizations are also major players; their interest in improving population health stems from the realization that health status is linked to the level of economic development and productivity in the local community. CHPs are initiated for other reasons as well, ranging from competition among community leaders for attention in the public arena to recognition of a community need by devotees of civic improvement, such as the Chamber of Commerce and service clubs.

The nature of the environment in which a CHP is initiated affects its development and strategic direction. Communities differ on several dimensions: resources and social capital/capacity; the degree of interaction

among community organizations, such as businesses, churches, and schools; the degree of psychological identification with a common geographic locality; and the strength of relations among local units (Warren 1963; Kreuter and Lezin 1998; Kreuter, Young, and Lezin 1999). Recent evidence from evaluations of community-based collaboration indicates that the level of community resources or support for the partnership prior to initiation is a critical determinant of future success (Kreuter and Lezin 1998; Kreuter, Young, and Lezin 1999).

Thus, it seems that variation in resources, relationships, history, and distributions of power and influence in communities will determine both the extent of planned change and who is likely to carry it out. Intervening variables or changes in community configurations may require the partnership to adopt new strategies for the governance and management of the affected organization(s). (Warren 1965).

Determining the Partnership's Domain and Setting the Strategic Direction

Determining a specific, easily articulated mission that reflects the interests of both individual organizational members and the larger community partnership is an important characteristic of effective CHP governance (Phillips and Springer 1997). Once set, the mission and associated goals largely dictate the organization's major areas of activity and functions and act as signals to both external and internal stakeholders of what the organization is about (Shortell and Kaluzny 1994). Externally, the mission and goals send a message to those who may wish to become involved (stakeholders), provide resources (funding agencies), or benefit from its existence (community residents). Internally, goals are a source of motivation and help to direct decision making.

The process of determining a specific mission and goals for the partnership can follow either a rational model of planned change (Sieder 1962) or pursue a more dynamic model of political bargaining and negotiations among the initial sponsors of the organization (Rossi 1960). The effectiveness of these different approaches depends largely on certain characteristics: internally, the makeup of the partnership's governing body, including the leaders' background and professions and the identity of major funders, is critical; externally, the community context in which the partnership operates is an important factor. For example, CHP leaders who are professionals or practitioners may be more oriented toward *tasks*

and more interested in setting goals with tangible and measurable outcomes. Community-based actors, on the other hand, may be drawn more to *process*, preferring to concentrate on integrating organizations from various sectors of the economy and building relationships among people who constitute the action system (Kramer and Specht 1969). Communities with well-developed infrastructures and revenue bases may be better able to support partnerships that tackle a broader scope of activity and goals than communities with few resources.

All partnerships need to ensure that their purpose and mission are properly *aligned* with the characteristics of both their internal members and the external community. It is important for them to articulate the mission in a well-defined, specific message. Tailoring the mission and goals to fit the goals of individual member organizations has been found to increase the chance that members will support the partnership, contribute resources, and remain active participants over time (Rein and Morris 1962). One study of the relations among health care agencies found that the inability to identify a common goal hindered interagency cooperation (Levine, White, and Paul 1967). Evidence from community-based partnerships indicates that having a well-defined mission and specific goals helps members to achieve a consensus and is associated with high levels of participation and community acceptance (Gamm, Rogers, and Work 1998; Phillips and Springer 1997; Wickizer, Wagner, and Cheadle 1998). The existence of a specific mission facilitates identification of appropriate coalition membership, thereby increasing the likelihood that member organizations will view the goals of the partnership as compatible with their own. Choosing a mission that reflects the needs of the external community, is supported by the community, and is realistic about the resources necessary to achieve the associated goals is also critical to the success of the partnership. A partnership may well be internally aligned in its mission, but if the external community is not ready to accept it, the partnership may be unable either to achieve measurable results or to sustain itself over the long term (Kreuter and Lezin 1998). The process by which CHP governance determines the mission and goals, and the nature of the mission and goals themselves, may differ, depending on the characteristics of a partnership's constituents and the conditions in the external environment. What is critical to all partnerships, however, is the ability to correctly perceive and align internal and external characteristics. Effective CHP governance must identify a mission, along with its corresponding goals, that is both specific in nature, fits closely with

member organizations' individual missions and goals, and is appropriate to the context of the community where the partnership is operating.

CHP management can support and sustain the alignment between internal and external stakeholders by facilitating the achievement of "domain consensus," defined as the degree to which members agree and accept each other's claims regarding products, services, and clientele. Domain consensus has been identified as a critical factor in the ability of CHPs to attain their goals (Levine, White, and Paul 1967; Gamm, Rogers, and Work 1998). The community organization literature discusses several methods that partnerships can use to achieve domain consensus. Improving member organizations' awareness of the goals, functions, problems, and operating restrictions of other organizations in the partnership is a proven method of reducing conflict (Levine, White, and Paul 1967). By analyzing the domain differences among member organizations in the early stages of partnership development, CHP managers may be able to identify mechanisms that will reduce tensions and improve collaboration. For example, they might bring in community leaders to facilitate discussions or use research findings to support and increase the legitimacy of defined goals (Rein and Morris 1962).

Research indicates that achieving consensus in community organizations whose mission is to integrate community actors often begins with small groups (Pernell 1985; Hyde 1986; Gutierrez and Lewis 1994). The small-group environment makes it easier to discuss the social and political issues involved in developing strategies for social change and to identify common goals. These small initiating groups include community leaders, representatives of citizen groups and institutions, and members of the scientific community. They provide legitimacy to the process of identifying goals and objectives, which are largely noncontroversial and in the community's best interest in that they contribute to community solidarity and reduce community conflict and strain (Rein and Morris 1962). Gaining legitimacy is important for securing community support, which is essential when CHP goals require grassroots community participation (Hageman, Zuckerman, Weiner, et al. 1998).

Partnership Composition

Choosing its membership from the available array of community actors and organizations is an important element of CHP governance. The partnership's scope and the nature of its mission and goals will determine

which constituents are appropriate for membership. Too much diversity or broad involvement, as well as too little, can lead to discord and lack of outcomes (Phillips and Springer 1997). For example, CHPs with a narrower scope, or a mission that targets a defined population or health problem, may perform better by limiting participation to groups that are working closely on tasks associated with that particular problem or with the selected group. Research has found that goals of *change* are often best achieved by applying a strategy of *individual rationality*, which calls for a limited number of stakeholders to be involved in making decisions (Rein and Morris 1962). Individual rationality is characterized by predetermined, specialized, or vested interests of a single group or of small groups of organizations that are less responsive to the needs and wishes of other local community organizations. Although this strategy may seem to be at odds with the general conception of intersectoral collaboration, proponents of individual rationality cite the "realism" or "correctness" of stated goals as an advantage, and they indicate that it is a better reflection of their preference for action over discussion than the collective model (Rein and Morris 1962).

Under a model of individual rationality, the primary constituents are the founders of the organization, who know what they are trying to achieve. Constituents are brought into the partnership on the basis of their ideology and like-minded commitment to the principles and goals of the organization. Although members may not agree about goals outside the partnership's sphere, they are able to achieve a high level of consensus on a narrow range of issues and goals (Schattschneider 1960).

In contrast, CHPs that are broader in scope, missions, and goals may benefit from wider participation and the support of diverse community interests. Studies show that when the purpose of collective action is *integration*—that is, bringing community actors together to address collective problems—a strategy of *collective rationality* is more appropriate (Rein and Morris 1962). Improving community health is a complex goal, and many believe that it requires collective action by diverse participants because the determinants of health are dispersed throughout many sectors of the community sectors (Evans and Stoddart 1990).

On many issues that have to do with values, however, collaboration is only possible if consensus can be reached. It is important for the governing body to anticipate conflict among the groups and to identify political issues that may hinder social change (Ristock 1990; West 1990). In many cases, it may be preferable for partners to be selected on the basis

of their perceived ability to reach a consensus on goals, rather than the degree to which they reflect the community at large.

Effective governance can be characterized by the strategic selection of participants that both reflect the nature of the mission and goals of the partnership and have the ability to work together effectively. The determining concept in strategic selection of constituents is overcoming differences that serve as barriers to community problem solving. Achieving this end may require adaptation of traditional democratic principles of decision making. This strategy, which adapts traditional conceptions of collective action to include only parties with similar values and goals, has been shown to increase the partnership's chance of realizing its goals (Warren 1965).

Management's ability to maintain member interest, foster links between the partnership and the external community, and communicate membership benefits is critical to the success and sustainability of CHPs. For example, Tulsa's Turning Point initiative recruited new members through presentations and web sites containing concise, factual information that clearly defined the benefits of membership in the coalition. These outreach efforts were designed to appeal to sectors of the community outside the social service and medical arenas (Christian and Edmonds 1998). Management also plays a key role in managing conflict between member organizations and solving turf issues (Alexander, Zuckerman, and Pointer 1995; Brown 1984). One study of community coalitions for prevention and health promotion found that member satisfaction and participation were related to a positive organizational climate and links with other organizations (Butterfoss, Goodman, and Wandersman 1996). CHP managers may foster a positive climate and fruitful interaction by clearly delineating each member's obligations and anticipated benefits (Doz and Hamel 1998).

Resources

An important function of governance is determining the level of resources necessary to implement and sustain CHP activities and then securing those resources from external and internal sources. Private foundations are a major source of CHP funding; state and federal grants that encourage collaborative efforts are another. Internally, member organizations are an important source of both financial contributions and human resources (Wandersman, Goodman, and Butterfoss 1993). Members contribute

financial funding, staff support, influence with policy makers, physical space for the organization, skills or knowledge, and external legitimacy (Knoke and Wright-Isak 1982; Gray 1985). Members that lack material resources owned by the collective organization or operate in environments of scarcity can take advantage of the pooled resources of the collective organization to enhance their own sustainability (Knoke and Wood 1981; Prestby and Wandersman 1985). It is important that for CHPs to map their resource needs accurately and incorporate this information into its membership recruitment strategies.

Notwithstanding the importance of internal member resources, maintaining external links with current and potential funding sources is also a critical task of CHP governance, especially when policy making and planned change are defined goals (Wandersman, Goodman, and Butterfoss 1993) or the level of community resources is low (flood, Shortell, and Scott 1994). A partnership's mission and goals can be legitimized through external actors' financial support or public backing in the form of endorsements by elected officials, support from government agencies, foundation grants, and volunteer support from local community groups and institutions. These gestures of solidarity provide evidence of how *central* the CHP is to the community. The literature suggests that CHPs that forge strong ties with the community and secure community-wide support will have a greater chance of obtaining the funding and resources necessary for long-run sustainability (Levine, White, and Paul 1967; Cheadle et al. 1997; Leduc 1983). The concept of *centrality*, defined as the extent to which the CHP becomes institutionalized and pivotal to the life of the community, is not well developed in the literature, however. We suggest that it is a critical dimension for sustainability, and we will develop its importance in our discussion of the typology. For example, CHPs with high centrality may benefit from more extensive links and greater exposure, which may help them to raise funds and gain support, both within and beyond the immediate community.

Overreliance on external support, especially nonlocal financing, can also have its drawbacks. Most sources of money have strings attached, and exclusive reliance on them inevitably subjects the partnership to increased outside control. For example, studies of public television programming found that demands exerted by external funding agencies affected the types of programming produced (Powell and Friedkin 1983), and categorical funding for specific activities or programs can limit flexibility. Additionally, the short-term nature of external funding presents

a problem for partnership stability and sustainability and may inhibit institutionalization of CHP programs in the community. The practice of short-term funding has increased in recent years because of increasing budgetary constraints and demands for oversight in programmatic expenditures at the federal level (Nadel 1995). The fact that the bulk of CHP funding is in the form of short-term grants may be one reason why there is so little evidence that CHPs are effective in creating system change or improving health status (Wickizer, Wagner, and Cheadle 1998).

CHPs can take several steps to improve the long-run stability of their funding. Having a staff person on board who is experienced in obtaining grants has been shown to increase community organizations' ability to obtain funding (Leopold 1979; Lorenz 1983). An experienced grantsman (or woman) may be aware of factors that affect the outcome of the grant process: direct links between the partnership and certain grant-making bodies; the partnership's chance of receiving funds from different external sources; the degree of competition for grant money; and the data collection that is necessary for preparing a grant application (Lorenz 1983). Involving funding agencies in the partnership's planning process has also improved the sustainability and flexibility of long-term funding in social work (Connell 1983). Developing volunteer participation is another resource strategy for reducing the uncertainty stemming from short-term funding and minimizing demands from external funding agencies.

CHP management carries out its critical role of coordinating grants and fiscal matters and developing new revenue sources by maintaining communication and links with both external actors and member organizations. Studies examining factors associated with volunteer participation in community-based organizations found that the more active participants were characterized as those who received significantly more perceived benefits than those were less active (Prestby, Wandersman, and Rich 1990; Wandersman, florin, and Meier 1987). The Healthy Communities project in Portland, Oregon, has used active outreach as a vehicle for building long-term relationships, increasing resources, and achieving future goals that require collaboration (Christian and Edmonds 1998). Effective management can help CHPs become central in their communities by frequently communicating the benefits of participation to members, identifying and dealing with member dissatisfaction or problems, and maintaining an active outreach agenda to promote the CHP's identity in the community.

Coordination and Integration Issues

Coordination, defined as managing a system of exchanges (Levine and White 1961), is a central concern to CHPs because their organizational members are likely to be dispersed and to vary in their interests and degree of involvement (Knoke and Wood 1981). Management's ability to coordinate or integrate its work among the various actors in a CHP depends on the characteristics of the constituents, the complexity of the tasks, and the strength of environmental constraint (Galaskiewicz 1985; Sofaer and Myrtle 1991). Partnerships with a history of collaboration or joint accomplishment may find it easier to coordinate work and divide responsibility because they have established relations of trust (Dolan 1993; Gulati 1995; Hageman, Zuckerman, Weiner, et al. 1998; Nelson, Rashid, Galvin, et al. 1999).

Partnerships whose member organizations produce similar products and services, compete for customers and market share, or view the community through different professional lenses may find that they disagree over turf issues, experience a certain amount of conflict, and have to work harder to coordinate their activities and to reach compromises (Himmelman 1996; Hageman et al. 1998; Weiner and Alexander 1998). Health professionals operating under a medical model, narrowly defined, often experience difficulty in collaborating with professionals from outside the health field to improve population health (Proenca 1998; Weiner, Alexander, and Zuckerman 1998). CHP management can reduce divisions among members by helping them to identify mutually valued goals that can only be attained through collaboration and tying the achievements of those goals to the partners' individual objectives. Explicitly acknowledging differences at the earliest states of program planning can help build better relations among partners with diverse interests (Cheadle et al. 1997). Hiring an expert facilitator to moderate discussions has also been a successful method of turning conflict into constructive dialogue (Weiner, Alexander, and Zuckerman 1998).

The degree of complexity that defines the organization's goals, programs, and activities will also affect the coordination of the partnership's work. The literature in institutional economics and interorganizational relations recognizes the need for different forms of governance, depending on the nature of the exchange relationship (Williamson 1981; Sofaer and Myrtle 1991; Begun, Luke, and Pointer 1990; Luke, Begun, and

Pointer 1999). The degree of uncertainty that exists among the actors, the types of products or services being exchanged, and the environmental context in which the exchanges occur will determine the degree of formalization or integration necessary to govern the transaction. Most CHPs can be categorized as hybrid organizations, representing an intermediate form of organization governed mainly through contractual relationships, which are at once more formal than pure spot-market transactions between independent actors and less formal than traditional hierarchical organizations (Williamson 1981). As hybrid organizations, CHP members retain their own identity but are connected to members of the partnership through established relationships, agreements, or contracts, both formal and informal.

"Contractual coordination" refers to the distribution of mutual exchange rights between the involved parties in order to govern the partnership. These rights define the operating procedures that govern the exchange and resolve possible conflicts between partners (Sobrero and Schrader 1998). Contractual coordination can vary in the degree of formality that governs the exchange relationships. There is considerable debate in the literature on the merits of more formal contracts versus less formal or loosely structured partnerships (Alexander, Comfort, and Weiner 1997; Schmitz, Henry, and Perlstadt 1997; Gamm, Rogers, and Work 1998; Kreuter and Lezin 1998). Some believe that formal contractual relationships, based on rules, defined procedures, and centralized decision making, are necessary to carry out and sustain a successful collaboration (Goodman and Steckler 1989; Butterfoss, Goodman, and Wandersman 1996; Schmitz, Henry, and Perlstadt 1997; Gamm, Rogers, and Work 1998). In many CHPs, however, less is more in terms of organizational structure. Evidence from CHP evaluations demonstrated that partnerships' ability to achieve goals was increased when the organizations focused on outcome-oriented programs rather than on organizational structure (Phillips and Springer 1997). Additionally, the voluntary nature of participation in CHPs limits the extent to which legal contracts can govern the exchange relationship.

In many cases, management must rely heavily on social control to coordinate members in the exchange relationship (Knoke and Wood 1981). Social control can be conceived as influence derived from interaction and mutual relations among social groups (Janowitz 1975). The degree of normative social control available to managers in a CHP is associated with the degree of membership commitment to the organization. High

levels of commitment are associated with high degrees of normative social control and help to direct members' efforts toward collective interests rather than individual pursuits (Knoke and Wood 1981). Management can use social control more effectively to coordinate a partnership's activities by emphasizing members' similarities, areas of domain consensus, and mutually shared goals. Studies have found that organizations with similar and mutually dependent goals work more closely together and are more committed to exchange relationships (Rein and Morris 1962; Cook 1995; Finnie 1998; Moyer, Coristine, MacLean, et al. 1999). For example, the North Carolina Community-Based Public Health Initiative found that a synergistic relationship centering on their mutual goals evolved among local officials, community organizations, and university faculty, which allowed them to break down boundaries (Hegner 1998). In the absence of domain or goal consensus, however, CHPs can still unify members by acting as a coordinating agency and serving as the liaison, mediator, and negotiator, and, in some cases, a provider of the funds that are needed to generate programmatic activity (Reid 1965).

The context in which the partnership operates will influence the relative effectiveness of different types of coordination mechanisms. The contingent nature of organizational structure has been long recognized (Thompson 1967; Lawrence and Lorsch 1969). From this perspective, the degree of formal coordination necessary for effective performance depends on the extent to which organizational tasks are complex and the operations environment is uncertain. Although researchers may debate the precise definition of complexity and uncertainty, in general higher levels of task complexity and environmental uncertainty are associated with decentralized structures, whereas lower levels of complexity and uncertainty are associated with centralized governance structures.

Evidence from CHP performance supports this "contingency" theory of organizational structure. For example, more informal, from the bottom up, or community ownership approaches to coordination and control are commonly associated with CHPs that have adopted complex goals, such as integration or capacity building, and whose constituents have little prior experience working collaboratively (Schmitz, Henry, and Perlstadt 1997). Participatory decision making is a key element of the Comprehensive Community Health Models initiatives. These projects demonstrate the ability of communities to achieve significant change when they are

provided with the necessary resources and information and are permitted to participate in the decision making process (Paul-Shaheen 1998). On the other hand, CHPs characterized by high levels of government funding, large numbers of constituents or stakeholders, and long histories of involvement or collaboration tend to benefit from a more formal approach that relies on centralized decision making and control (Alexander, Comfort, and Weiner 1997; Gamm, Rogers, and Work 1998). One study found that strategic alliances for community health benefit from strong leadership and a shared vision, which facilitates quick decision making (Nelson et al. 1999).

Correctly matching the degree of formalization necessary for effective coordination of work and information transfer with characteristics of partnership members and the external environment can improve communication, reduce uncertainty, and avoid conflict. Although conflict is an inherent part of any social organization (Mack 1965), it emerges as a problem more often when several organizations with diverse interests try to work together (Mizrahi and Rosenthal 1992), and it can result in polarization and distortion, even becoming an end in itself (Alinsky 1989). However, conflict can also benefit CHPs by sharpening discussion on issues, leading to creative approaches, and enhancing leadership. Conflict is often a necessary catalyst for effecting significant social change (Coser 1956).

Devising effective coordinating mechanisms to manage conflict requires negotiation and compromise (Brown 1984). CHP managers must develop a new set of skills as negotiators, mediators of conflict, and facilitators of communication, both internally, between members, and externally, between the organization and external constituents. Frequent meetings and a well-developed system of internal communication have been cited as effective mechanisms for reducing misunderstandings and alleviating conflict (Feighery and Rogers 1989; Andrews 1990; Cohen, Baer, and Satterwhite 1991). Additionally, familiarity with the types of issues and the distribution of power among groups can help managers to select the mechanisms that will facilitate the most constructive solutions. Research suggests that small, single-issue partnerships may benefit from a more participatory decision-making model, whereas larger, multi-issue partnerships may find that a working-consensus model better meets their needs (Brown 1984). Success can also reduce conflict and increase cohesiveness in partnerships. Jointly earned accomplishment is self-reinforcing and solidifies member trust.

Accountability

Accountability, defined as a process by which a party justifies its actions and policies (Emanuel and Emanuel 1997), is a key aspect of governance (Montagna 1990; Power 1997). CHPs may be held accountable under the charitable trust laws that govern all nonprofit organizations (Hansmann 1980). Charitable trust laws impose a "nondistribution" constraint that prohibits a nonprofit organization from extracting profits and charges its governing board with fiduciary responsibility for upholding the mission and integrity of the organization. Although charitable trust laws offer some measure of accountability for CHP stakeholders, they do not afford a way to quantify and measure concrete achievement. In addition, as a mechanism for accountability, charitable trust laws have lost some legitimacy in recent years owing to reports of excessive executive compensation among nonprofit institutions, lack of board oversight and accountability, loss of mission, misleading fund raising, and self-dealing among nonprofit managers (Hansman 1981; Cain 1999). The failure of many nonprofit charitable organizations to inform the public adequately about their activities, to diversify their staffs and boards sufficiently, to establish and adhere to conflict-of-interest statements, and to provide mechanisms for citizen input undermines the efficacy of self-regulation practices of accountability for CHPs (Russell 1993; Covington 1994).

Providing measurable results that are easily recognizable and accepted by a wide variety of stakeholders is critical to the long-run sustainability of CHPs. Currently, CHPs have found it difficult to do this, largely because of problems in measuring population health status and health-system change. Unlike most business organizations, which rely on traditional mechanisms of accountability, such as internal audits and income statements, to provide standard and institutionalized measures of effectiveness (Rose and Miller 1992; Power 1997), organizations whose mission it is to improve health must find tools that effectively measure changes in health status. Although progress is being made, no validated methods have yet emerged to measure health outcomes at the population level over the relevant time frames (Wolfson, Hourigan, and Johnson 1998), nor are there accepted definitions of population health status (Kindig 1998). Even if it were possible to measure population health status or system change accurately, it is difficult to demonstrate a cause-and-effect relation between those

outcomes and CHP activities. Thus, despite the demand for rigorous program evaluation as a mechanism of accountability, CHPs have few established procedures or institutions to provide or facilitate such evaluation.

Lacking reliable disease-specific or population health measures of health status or system change, CHPs may implement alternative performance indicators like the ones recently developed in vertically integrated health systems. For example, the Consortium Research on Indicators of System Performance (CRISP) project has developed measures of performance for integrated health care systems that focus on the health status of defined populations. Such measures include patient-reported health status, community benefit, illness prevention, satisfaction, and financial performance (Zajac, Green-Weir, and Nerenz 1995). Formative Evaluation, Consultation, and System Technique (FORECAST), which was developed to evaluate community partnerships, is another example of an evaluation mechanism designed to link partnership plans and programs with impact assessments (Kreuter, Lezin, and Young 1999). Prevention Plus II, a four-step program assessment guide developed for the Office of Substance Abuse Prevention, also tries to tie activities to outcomes and impacts through the use of a logic–model approach (Kreuter, Lezin, and Young 1999). Other types of evaluation measures are applied to processes, such as participation, planning products, media coverage, financial resources generated and obtained, and specific services. Satisfaction ratings from partnership members can also be the basis for external accountability and intermediate outcome measures, such as community actions to define new programs, policies, or practices. These measures can be tracked over time to determine if they are associated with subsequent changes in the outcomes that the partnership is addressing (Kreuter, Lezin, and Young 1999).

Although CHP goals are usually established for the long term, it is important to assess intermediate outcomes as evidence of progress. Demonstrating short-run success and "quick wins" has been cited as important in maintaining the motivation of members and organizational credibility (Croan and Lees 1979; Brown 1984; Hord 1986). Short-term quick wins can be especially helpful in gaining legitimacy and support for more complex, long-term goals during the early stages of partnership development. Providing evidence that goals have been attained, even in the short run, is an important element of accountability in community organizations that rely on volunteer participation and external

funding sources (Wandersman, Goodman, and Butterfoss 1993; Minkler 1996). The need for short-term, intermediate achievement should complement, rather than replace, long-term goals. Effective CHP governance must achieve a proper balance between short-term wins and long-term achievement.

Internal accountability, defined as keeping member organizations accountable for their actions and role in the partnership, is just as important as external accountability in demonstrating evidence of achievement. Empowerment evaluation, which involves members of the organization in the process, has been cited as an effective mechanism for internal accountability (Fawcett, Paine-Andrews and Francisco 1996; Coombe 1997). Empowerment evaluation allows members to define the agenda, determine which questions to ask and which issues to investigate, and interpret results (Eng and Parker 1994; Connell, Kubisch, Schorr, et al. 1995; Coombe 1997), and it has been shown to increase membership participation and investment. Despite relatively high costs and the skill and training required for its implementation, empowerment evaluation can be a valuable tool for increasing members' accountability to one another and sustaining participation. CHPs with larger infrastructures, more resources, and a membership with evaluation skills, or access to such skills, are better candidates for empowerment evaluation than partnerships without such resources and skills.

Summary

A number of intersecting lessons emerges from the review of the existing literature. One of the most important is the role played by *context*, a term that describes the internal and external stakeholders, the community's capacities and resources, the extent to which partnership organizations have had previous experience with each other, and the current challenges facing the community. Each factor must be understood by those governing, managing, and funding community health partnerships so they can determine the most suitable structures and processes for operating effectively. The challenge for CHP governance and management is to align the partnership's internal operations and strategic direction correctly with the characteristics and demands of the external environment.

Second, it is important to understand the reasons for organizing the partnership, or its *strategic intent*. The form and functioning of a partnership are contingent on its strategic intent and may change over time.

In particular, local politics must be taken into account, recognizing that the "opportunity to improve community health" is also a political stage for various community groups to advance their causes. In this regard, it appears to matter whether partnerships dominated by professionals, like school principals, city managers, health department officials, or hospital executives, have been organized for different reasons than grassroots organizations. The efforts of the former are likely to be characterized by relatively top-down plans for change, whereas those of the latter tend to be informal processes that work from the bottom up.

A third lesson involves establishing the degree of *partnership heterogeneity* that is appropriate to the problems to be addressed. In general, the more complex and diverse the problems, the greater the need for a range of partnership organizations comprising both task-oriented, professionally dominated organizations and process-oriented, informal, community grassroots organizations. It appears that an increase in the variety and complexity of problems to be addressed is accompanied by a greater need for both collective and individual rationality. This involves balancing the need for legitimacy and the pressure to act and produce results. In fact, one potential indicator of the extent of *systemic change* that has been achieved by a community health partnership may be the extent to which the partnership has "rearranged" the legitimacy-granting roles of existing institutions in the community.

A fourth lesson involves the need for a *diversified resource base*. Too much reliance on a single source of funds or a few funders can divert the partnership away from its original goals and objectives in pursuit of financial viability. Although it is important for community health partnerships to be appropriately opportunistic, "managing the grant dollar" can displace the original goals of addressing the community's prioritized health problems. A partnership's membership base is often its richest resource for obtaining financial and other types of contributions. Effective governance and management will use these resources as leverage for establishing links to other community institutions in order to become more sustainable.

A fifth lesson involves the importance of assessing the *types of coordination* needed among partnership members. The partnership can play a relatively loose coordinating role when individual members agree on their respective roles in addressing issues at hand. In such cases, the partnership can serve more as a broker of information, resources, and contacts, thereby helping to fill "structural holes" in the community's

network of relationships (Burt 1997). It also appears that formal, contractual coordination may be more effective when partners have worked together many times and when the problems they are addressing are relatively simple. In contrast, more informal, informational coordination may be called for when partners have had less experience working together and are working on more complex goals and problems. In reality, both forms of coordination are likely to be needed. Social-control mechanisms will continue to be important for the work of member organizations.

A final lesson is that community health partnerships must meet increased *demands for accountability* from multiple sources. Most partnerships are poorly organized to meet these demands and lack validated outcomes tools, particularly for measuring population health and documenting the impact of CHP projects on the health status of individuals, groups, and the larger community. Lacking ideal outcome measures of population health status and system change, CHPs must choose intermediate, quantifiable goals and continually monitor their own effectiveness, based on both traditional evaluation tools and empowerment evaluation, which more directly involves the whole partnership in the evaluation process.

This summary represents a relatively informal narrative summary of the major lessons from the literature. In our concluding section, we will formalize some of these important lessons by developing a typology for the governance and management of effective community health partnerships. From the typology we derive specific guidelines for those who are governing, managing, and funding such partnerships and present examples of specific propositions to be tested by the evaluation and research communities.

A Typology of Community Health Partnerships

A review of the literature suggests that CHPs must position themselves both externally and internally to achieve their goals and objectives. Externally, they must deal with the political economy of the environment and acquire the necessary resources to accomplish their mission (Pfeffer and Salancik 1978; Aldrich 1979). Internally, they must persuade individual members to unite behind a shared vision and mission, develop and execute a plan for implementation, maintain member commitment

and interest, resolve conflict, track progress, and meet the accountability demands of stakeholders.

These simultaneous demands are captured in the "triangle of strategic alignment" (fig. 1). Effective partnerships are more likely to align their strategies with environmental demands; devise strategies that they are capable of executing; and adapt their capabilities to meet the external environment.

The strategy adopted by the partnership to achieve its goals and objectives must meet the demands of the environment as reflected by the health problems of the community and the political, social, legal, and economic forces within which these problems are embedded. At the same time, the CHP will only be able to implement its strategies if it has the capabilities, such as its resources, to do so and if these capabilities match the demands of the environment. For example, a CHP's objective may be to reduce teenage pregnancy by 50 percent over a three-year period. Its strategy for accomplishing this objective must be aligned with the politics and culture of the community, as reflected in its ethnic composition, religious beliefs, views on children, past history, and so on. At the same time, the likely success of its strategy will depend on the involvement of relevant organizations, relations with schools and religious organizations, ability to communicate and educate, and other related internal capabilities. These capabilities, in turn, must be compatible with, and relevant to, the larger environment in which the problem of teenage pregnancy exists.

Based on the triangle of strategic alignment and broad framework, outlined in figure 2, we suggest seven dimensions that can be used to classify CHPs for purposes of public policy, practice, and future research:

1. the nature of the problems(s) addressed
2. the partnership composition
3. the differentiation in services provided and the resource/funding mix
4. the coordination and integration of member organizations
5. the accountability mechanisms used
6. centrality
7. alignment

Each of these is described and developed in the following sections.

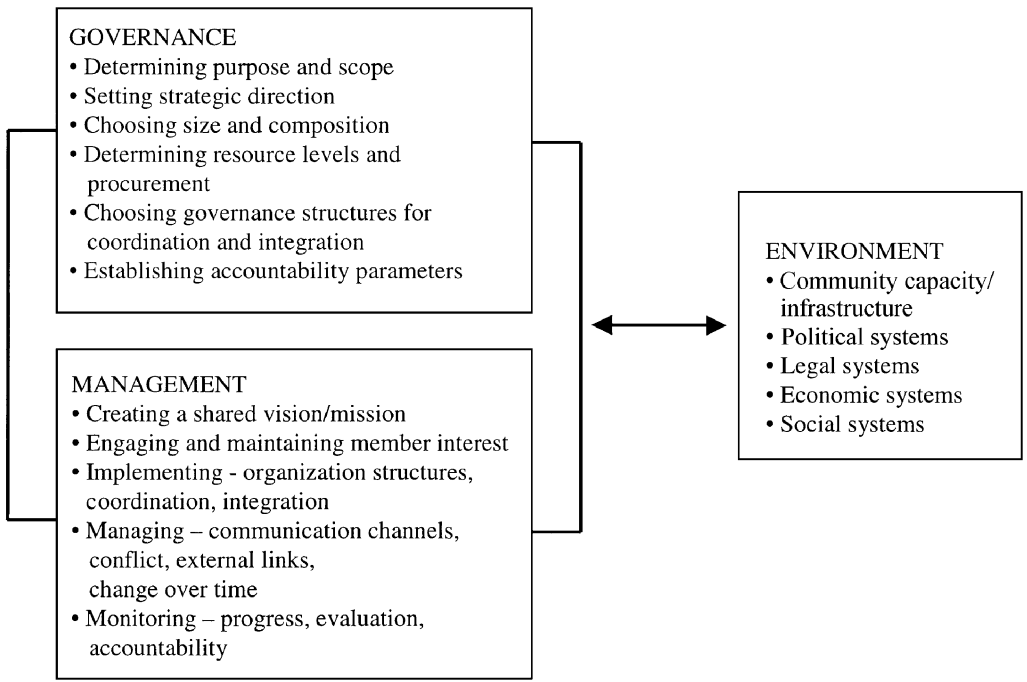


FIG. 2. Conceptual framework for assessing the governance and management of community health partnerships.

Nature of the Problem Addressed

Most community health partnerships are formed to create change in the health status of community residents, at least as a long-run goal. Goals of change can address single problems such as lead poisoning (Kass and Freudenberg 1997), substance abuse (Aktan, Kumpfer, and Turner 1996; Lewis, Paine-Andrews, Fawcett, et al. 1996), or HIV infection (Kachur, Sonnega, and Cintron 1992; McKinney, Wieland, Bowen, et al. 1993; Myers, Pfeiffle, and Hinsdale 1994), or broader-based community health issues (Himmelman 1996; Bazzoli, Stein, Alexander, et al. 1997; Bogue, Antia, Harmata, et al. 1997; Cheadle et al. 1997), such as access to care or improving continuity of care. Even when focusing on a single disease, like AIDS, or a health issue, like substance abuse or teenage pregnancy, each CHP is faced with a different problem, which can vary according to the number of people affected, the severity of the problem, and its duration.

CHPs are also created with the goals of integrating community actors and organizations and coordinating services (Kramer and Specht 1969). Addressing problems of integration calls for different organizational strengths than those needed to tackle specific health problems that are affecting community health status. Any systematic assessment of the effectiveness of a CHP must take into account the challenges of the problem set that the partnership is attempting to address, just as evaluations of outcomes of clinical care must adjust for risk in order to account for differences in the severity of the illness experienced by each patient. Addressing more complex, severe, or extensive problems will require greater partnership capabilities.

Partnership Composition (Including Size)

The partnership composition-size dimension refers to the number of organizational members and individual people involved (some organizations may have more than one representative) at multiple levels or entities of the partnership. These entities typically take the form of a governing board or steering council, a management or operations team and support staff, and various committees, task forces, and councils. Some partnerships may designate different levels or categories of membership, such as full working partners, participating partners, and informing partners (Bogue et al. 1997). A full working partner typically commits both time,

staff, and resources to the partnership and plays a leadership role. A participating partner usually commits time to the partnership and joins in making decisions. An informing partner is usually not actively involved in making decisions but is kept informed and generally supports the partnership's activities.

Composition refers to the relative degree of homogeneity versus heterogeneity regarding certain organizational characteristics: public-sector organizations versus private-sector organizations; health versus education versus social-welfare agencies; and individual member characteristics, such as age, gender, ethnicity, and years of experience with either a specific member organization or the partnership at large. CHPs composed of numerous constituents from a wide variety of economic sectors can be described as heterogeneous, compared with CHPs whose members have similar backgrounds. A more diverse, heterogeneous partnership will demand more highly developed leadership, coordination, and conflict-management skills.

Differentiation

The concept of differentiation, which was originally developed by Lawrence and Lorsch (1967), refers to the number of different activities, services, goals, and orientations in which a partnership is engaged. In the context of a CHP, differentiation refers to several aspects, including the number and types of services it provides and its mix of resources and funding. The more differentiated are a partnership's services and resources, both financial and human, the greater are the demands placed on its abilities to coordinate and monitor progress.

Coordination and Integration

Consistent with existing literature (Lawrence and Lorsch 1967; Van de Ven and Koenig 1976; Shortell, Gillies, Anderson, et al. 2000), integration refers to mechanisms of coordination used to achieve partnership objectives. There are three major mechanisms: ownership; contractual relations or alliances; and informal interactions characterized by norms of trust and reciprocity. In the case of ownership, the services provided by a partnership in pursuit of its objectives can be carried out by arranging for it as an entity to own the assets of the service delivery unit. The economics literature typically refers to this as "vertical integration"

(Williamson 1981; Robinson and Casalino 1995; Conrad and Shortell 1996). In the case of contractual relations, party configurations of two or more partners, or members of a partnership and outside organizations, or the entire partnership and outside organizations agree to deliver services based on the terms of a written contract. This is commonly referred to as "virtual integration" (Robinson and Casalino 1995; Conrad and Shortell 1996). Both vertical and virtual integration are achieved through relatively formal methods of coordination. Finally, services can be provided and coordinated by member organizations through informal interaction and understandings, which are based on norms of trust, cooperation, and reciprocity (Butterfoss, Goodman, and Wandersman 1996; Potapchuk, Crocker and Schechter 1997). It may be that the more numerous and various are the problems a partnership addresses, and the more differentiated its constituents and funding agencies, the more likely it is that all three major forms of integration will be present to achieve the partnership's objectives.

CHPs vary in the extent to which they employ different mechanisms to govern partner relations. The degree of formal integration will affect how decisions are made, and by whom. Two broad sets of decisions are of interest: those of a policy nature, such as setting the guiding purpose and determining membership composition; and those of an operational nature, such as providing services and measuring outcomes. Either type may call for different levels of decision-making within the partnership, varying from relatively centralized decisions by the governing board or top management to decentralized decisions by subregional councils, committees, and individual staff members. The scope and severity of the problems addressed by the partnership, relative to its size and composition, as well as the context in which the partnership was initiated and the degree of accountability demanded by outside funders, will typically influence the choice of governance structure and the levels of internal decision-making.

Accountability

Accountability refers to the mechanisms employed by CHPs to justify their actions and policies, both to external stakeholders and, internally, to other members. CHPs are accountable to a wide variety of stakeholders, including private foundations, government agencies, community organizations, residents, and to one another as partners in the joint effort to

improve health. Additionally, partnerships focus to varying degrees on providing evidence of short-term versus long-term achievements. Mechanisms of accountability include quantitative, process-based measures, intermediate outcomes, selected population health measures, and more qualitative satisfaction ratings. The types of accountability mechanisms that are necessary and appropriate for a partnership depend on the heterogeneity of stakeholders, partnership goals, and available evaluation tools.

Centrality

Centrality is concerned with the importance and influence of the partnership within the power structure and organizational ecology of its community. Research suggests that centrality is positively related to power (Brass and Burkhardt 1992) and influence in community affairs (Cook 1977). Results consistent with the power–centrality nexus have been demonstrated across organizational relations (Galaskiewicz 1979), within professional networks (Breiger 1976), and among elite community social networks (Laumann and Papi 1976). CHP centrality may be evaluated by examining the extent to which the partnership is viewed as a powerful and influential "actor" in the community relative to other coalitions, political entities, and even individual organizations that may themselves be members of the partnership. Does the community look to the partnership to address important health issues? Is the partnership bypassed on certain issues? To what extent does the community power structure listen to what it says? Does the partnership contribute relevant input on issues that are important to its own mission? A CHP's membership composition, the problems it addresses, the services it offers, and its funding sources may affect its relative centrality. These factors are important to the development of social capital, defined in terms of the quality of its relations, that can be used to achieve desired benefits (Burt 1997). One would expect that the degree to which a a CHP occupies a central position in the community will determine its ability to achieve its objectives and sustain itself over time.

Alignment

Alignment refers to the nature of the interactions between the external environment and the organization (Emery and Trist 1965; Thompson 1967; Pfeffer and Salancik 1978), the organization's strategy and structure (Chandler 1966), and the organization's structure and behavioral

capabilities (Katz and Kahn 1978; Kimberly 1984). When a partnership is designing a governance structure that is most suitable for coordinating its activities, the partners must simultaneously decide on the nature and scope of the problems they wish to address, consider the external environment, select the appropriate strategy for accomplishing the partnership's goals, and take into account the membership composition and task complexity. Does the community support the goals of the partnership? Is the partnership composition largely heterogeneous or homogeneous, and is there a history of prior collaboration? What strategies best enable the partnership to attain its goals, given the environmental context, composition, and available resources? A partnership's ability to align its strategy and structure so that it can work harmoniously within its environment will affect its ability to position the organization for success (Kimberly and Zajac 1985; Shortell and Zajac 1990).

Table 1 summarizes the seven dimensions of the typology and lists examples of suggested measures. We view these dimensions as largely endogenous and under the control and choice of the partnership, despite the clear influence of external community dynamics. Table 2 illustrates possible empirical results that would yield various combinations of characteristics to form a parsimonious taxonomy of community-health

TABLE 1
Sample Taxonomy That Classifies CHPs Based on a Combination of the Six Dimensions

External alignment[a]	Internal alignment[b]	Centrality	Suggested category name
High	High	High	High alignment/high influence
High	High	Low	High alignment/low influence
High	Low	High	External alignment/high influence
High	Low	Low	External alignment/low influence
Low	High	High	Internal alignment/high influence
Low	High	Low	Internal alignment/low influence
Low	Low	High	Low alignment/high influence
Low	Low	Low	Low alignment/low influence

[a]External alignment = match between the partnership composition and the breadth or scope of problems addressed.
[b]Internal alignment = match between the number of different services/initiatives undertaken (i.e., differentiation), the level of decision-making, and mechanisms of coordination/integration.

TABLE 2
Dimensions of a Typology of Community Health Partnerships and Sample Measures

Dimensions	Examples of Measures
Nature of problems addressed	
Breadth/scope	• Number of different health conditions/ problems addressed • Number of people affected
Mission and goals	• Goals of change or integration • Long-term vs. short-term goals
Partnership composition	
Size	• Number of organizations involved • Number of individuals involved
Heterogeneity	• Number of public-sector organizations involved in leadership roles • Mix of public- and private-sector organizations, grassroots organizations, etc.
Differentiation	
Services provided	• Number of different programs/ services provided
Resource/funding mix	• Percent of funding from government agencies • Percent of funding from private foundations • Percent of funding from member organizations • Average length of funding period for different sources • Relative dependence on short-term vs. long-term funds
Coordination and integration	
Degree of formalization	• Partnership is unified under single ownership • Partnership is coordinated through formal contracts • Partnership relies on informal agreements, social control, reciprocity, and trust
Centralization of decision making	• Extent to which operating and policy decisions are made at various levels (for example, strategic plans, allocation of resources, selection of staff, writing reports, adding or deleting services, incorporating new members into the partnership)
Accountability	
External	• Use of professional/traditional evaluation methods

(*continued*)

TABLE 2 *continued*

Dimensions	Examples of Measures
	• Use of outcome-oriented evaluation tools • Community feedback loops in place
Internal	• Use of empowerment evaluation • Formal rules for conict resolution
Centrality	• Importance of the partnership in the community —Backing from elected officials —Newspaper/media coverage —Requests for participation by other organizations —Presence of interlocking board members —Relative size of CHP budget
Alignment	
External	• Match between problems addressed and partnership composition • Match between partnership composition and community priorities
Internal	• Match between partnership task complexity (differentiation) and governance structures (coordination and control)

partnerships. External alignment matches partnership composition with the breadth or scope of problems addressed. Internal alignment matches differentiation with the coordination/integration mechanisms used by the partnership. External alignment, internal alignment, and centrality are shown in all possible combinations of "high" and "low" metrics. Where all three are high, for example, we suggest that the result is a "high alignment–high influence" partnership. Where all three are low, there is a "low alignment–low influence" partnership. The combination of high external alignment and low internal alignment, but with high centrality (row 3), yields a partnership with "external alignment–high influence." The remaining rows show the other various combinations.

We suggest that the typology/taxonomy can be used as both a road map for developing more effective CHPs and for stimulating further research on the effectiveness of CHPs. For those interested in starting CHPs or improving existing partnerships, the typology/taxonomy extends the current literature by emphasizing the contingent and relational nature of key dimensions of partnerships that must be governed and managed. Figures 3 to 6 provide an abbreviated set of "decision trees" as guides,

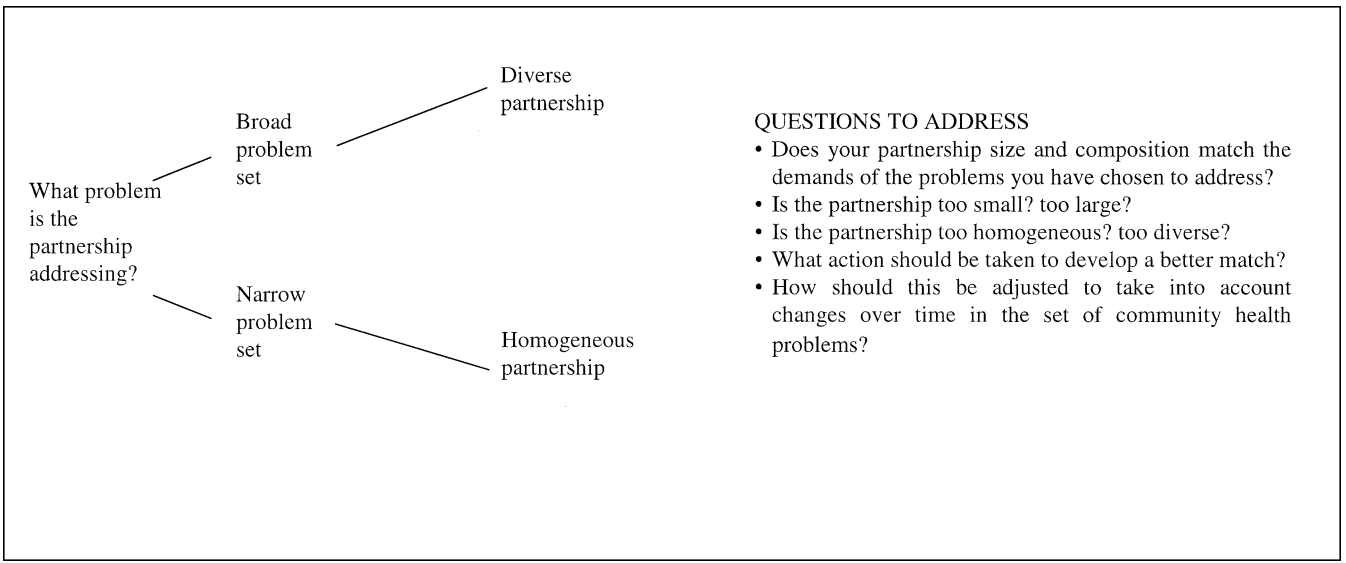


FIG. 3. External alignment issues.

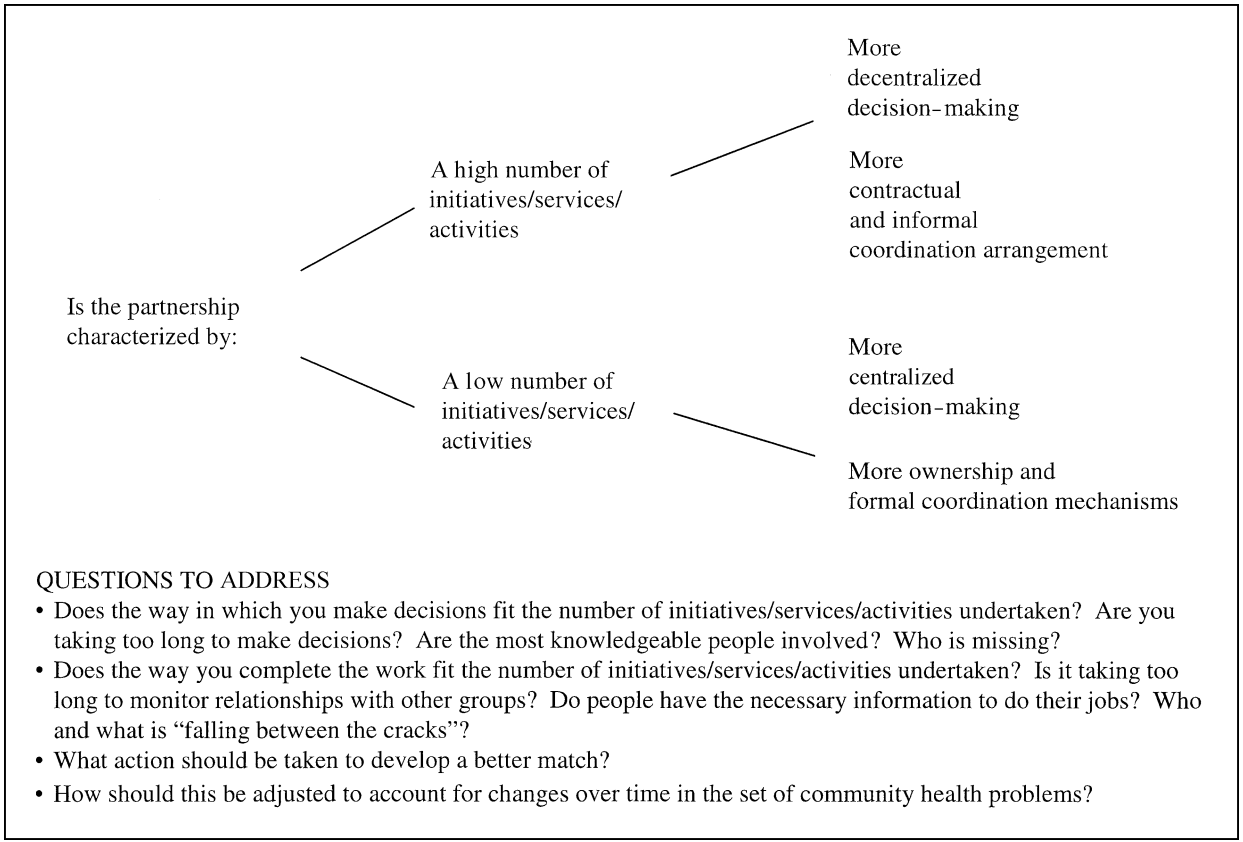
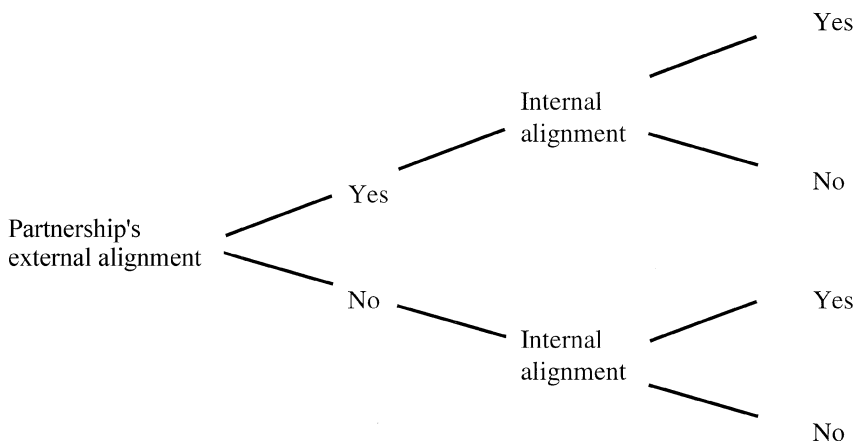


FIG. 4. Internal alignment issues.



QUESTIONS TO ADDRESS

- Are the partnership's resources being used in the most efficient and effective ways? Is the partnership failure to meet its goals and objectives because of insufficient internal alignment of decision-making and lack of coordination of work and the volume and nature of the initiatives?
- Are the efforts of the partnership compromised or failing to make the desired impact because the partnership is not well aligned with the nature of the problem addressed? Is the partnership internally effective in aligning activities, decision-making, and coordination but externally ineffective in accomplishing goals?

FIG. 5. External and internal alignment issues.

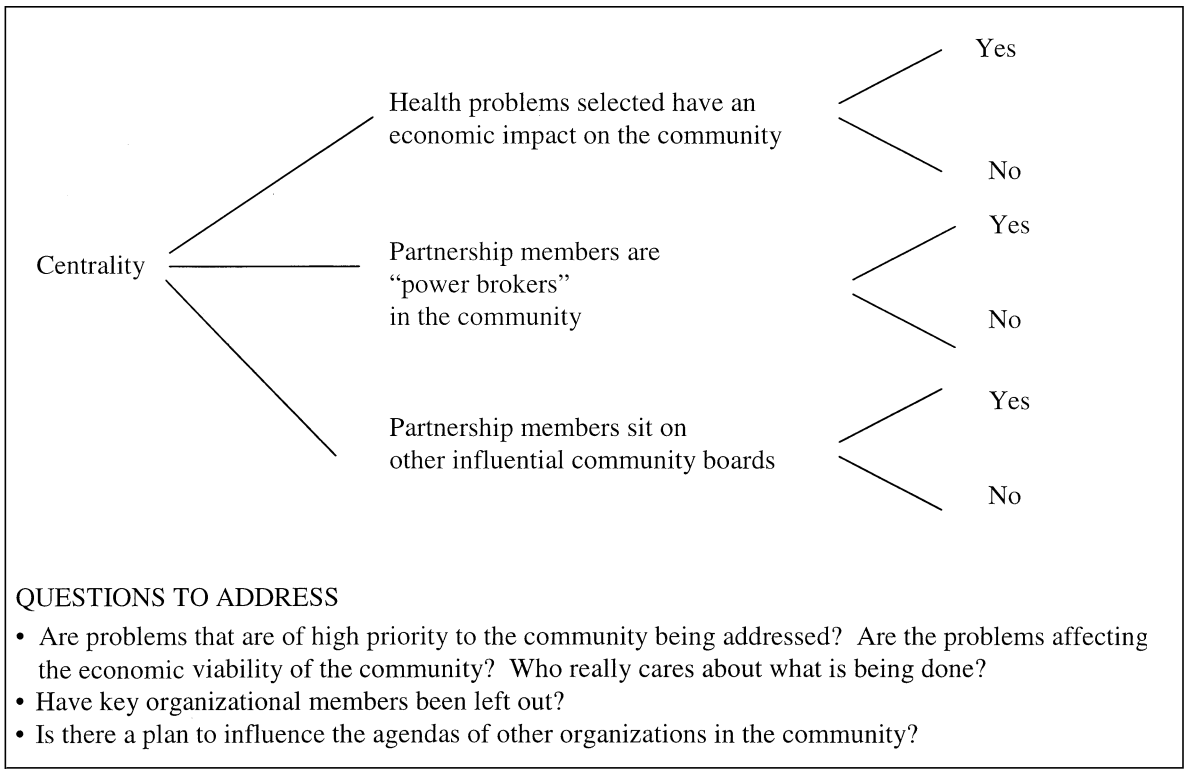


FIG. 6. Questions about centrality issues.

with examples of questions that the partnership governance and management should address when they are making decisions. These decision trees can also be used by funders and policy makers who wish to promote the effectiveness of such partnerships.

For example, figure 3 asks a partnership to assess its external alignment. A broad problem set suggests the need for a more diverse partnership, whereas a narrow problem set calls for a more homogeneous partnership. The central questions revolve around the match between partnership size and composition and the nature of the problem to be addressed. Figure 4 addresses internal alignment; figure 5, the combination of internal and external alignment; and figure 6, centrality. In the latter case, we suggest that the partnership will enjoy a higher probability of success and long-run sustainability if it takes on health problems that have an economic impact on community health; if the partnership includes some community "power brokers"; and if partnership members, in turn, sit on influential community boards.

The typology/taxonomy can also be used to generate propositions for further research. Underlying them is the suggestion put forth by resource dependency theory that external alignment is most clearly related to the partnership's ability to obtain needed resources (Pfeffer and Salancik 1978; Aldrich 1979). Structural contingency theory would link internal alignment most closely with the ability to use those resources effectively and efficiently in achieving the partnership's objectives (Lawrence and Lorsch 1967; Donaldson and Preston 1995), which is also compatible with the resource capabilities perspective (Foss 1997). Further, centrality, in line with social network theory, is assumed to be most integral to the ability of the partnership to achieve legitimacy and social capital (Nohria and Eccles 1992; Uzzi 1996; Burt 1997), a view that institutional theory would support as well (Powell and DiMaggio 1991; Scott 1994). Based on these considerations, the following list provides examples of propositions or hypotheses that can be examined, recognizing that the dimensions may not be of equal importance.

P1: The greater the degree of external alignment, the greater the CHP's ability to obtain needed resources.

P2: The greater the degree of internal alignment, the greater the CHP's ability to implement initiatives.

P3: The greater the partnership's degree of centrality, the greater its ability to sustain its activities over time.

P4: High levels of external and internal alignment, combined with high centrality, will be associated with long-run sustainable performance.
P5: A high degree of external and internal alignment, combined with low centrality, will be associated with short-run performance but also with an inability to sustain success in the long run.
P6: A high degree of external alignment and centrality will be positively associated with a long-run ability to secure resources.
P7: A high degree of external alignment, combined with a low degree of centrality, will be associated with only a short-run ability to secure resources.
P8: A high degree of internal alignment, combined with high centrality, will result in a long-run ability to use resources effectively and efficiently.
P9: A high degree of internal alignment, but with a low degree of centrality, will be positively associated with only a short-run ability to use and implement resources effectively.
P10: A low degree of external and internal alignment, combined with high centrality, will be associated with a lower likelihood of the partnership's achieving its goals and objectives and a higher likelihood that it will lose its legitimacy and credibility over time.
P11: Low levels of external and internal alignment, combined with low centrality, will be associated with partnership failure and likely demise.

Conclusion

The governance and management of a CHP must improve the network's ability to achieve its objective of improving community health. This requires the partnership to attain both internal and external alignment for effective functioning. The governance function is primarily concerned with the alignment between the partnership and external stakeholders, whereas the management function focuses on aligning internal members. Together, they must align environmental forces, partnership strategy, and partnership capabilities.

Based on the framework and review of the existing literature, we identified seven salient dimensions that can be used to classify partnerships. We also suggested several measures of each dimension. We

provided an example of how these might be further reduced into an empirical taxonomy based on the notions of external alignment, internal alignment, and centrality. We then showed how the typology/taxonomy could be used to improve partnership performance and to generate propositions for further research.

The proposed typology/taxonomy is viewed as preliminary and exploratory. It is intended as a starting point for further discussion and examination. Clearly, not all issues are addressed. For example, the taxonomy does not directly address issues of how the dimensions might vary depending on the stage of the partnership in its life cycle: early start-up; rapid growth; maturity; or in decline (D'Aunno and Zuckerman 1987). Also, any typology/taxonomy is inherently "deterministic" in nature. In the real world, partnerships may be difficult to pigeonhole. Clearly, "hybrids" will exist.

At this time, the main value of the typology/taxonomy is for use as a suggested framework that can be modified after it has been tested. Its utility will be uncovered by members of community health partnerships, organizations that fund the partnerships, and policy makers who influence such partnerships in their efforts to achieve the objective of improving community health. For researchers, the utility of the framework will emerge from its ability to stimulate research that furthers the knowledge and understanding of community health partnerships.

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